STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	JLTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUII	DING	00	COMPLETED	
		155446	B. WIN			08/05/2	011
			В. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				ILKIE DRIVE		
COVING	TON MANOR HEAL	TH AND REHABILITATION CENTI	ER		NAYNE, IN46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
			ļ				
		r the Investigation of	F0	000			
	Complaint IN000	094006.					
	Complaint IN000	094006-Substantiated.					
	Federal/ State de	ficiencies related to the					
		ted at F282, F312, F353					
	and F441.						
	and 1441.						
	Unrelated deficie	encies are cited					
	Omerated deficie	sheres are cited.					
	Survey dates: Au	igust 3, 4, and 5, 2011.					
	Facility number:	000476					
	-						
	Provider number						
	AIM number:	100290870					
	Carryon, tooms						
	Survey team:	DNITC					
	Christine Fodrea	·					
	Julie Wagoner, R	.N					
	Census bed type:						
	SNF/NF:	132					
	Total: 132						
	Census payor typ	oe:					
	Medicare: 13						
	Medicaid: 88						
	Other: 31						
	Total: 132						
	10181. 132						
	C1	11					
	Sample:	11					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 7VIW11 Facility ID: 000476 If continuation sheet Page 1 of 47

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155446			A. BUI	LDING	NSTRUCTION 00	(X3) DATE S COMPL 08/05/2	ETED
NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CE			B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE ILKIE DRIVE VAYNE, IN46804		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR These deficiencie cited in accordan	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) es reflect state findings ce with 410 IAC 16.2. completed on August 10, lkner, RN		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
F0279 SS=D	resident's comprese The facility must do care plan for each measurable object a resident's medic psychosocial needs comprehensive as The care plan must are to be furnished resident's highest mental, and psychological required under \$44 would otherwise bout are not provided exercise of rights or right to refuse treat Based on observative record review, the formulate approars specific and individualized care	velop, review and revise the nensive plan of care. evelop a comprehensive resident that includes tives and timetables to meet al, nursing, and mental and les that are identified in the	F0	0279	F 279 1. Resident's C, D, and H caplans were revised to include frequency of continence managand method of transfer. 2. All resident care plans will reviewed to ensure continence management plans and methods transfer are included and update appropriate. 3. Licensed staff will be	ement	08/30/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7VIW11

Facility ID: 000476

If continuation sheet

Page 2 of 47

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155446		A. BUI	ILDING	NSTRUCTION 00	(X3) DATE COMPI 08/05/2	LETED
	PROVIDER OR SUPPLIER		B. WIN	5700 W	DDRESS, CITY, STATE, ZIP CODE ILKIE DRIVE VAYNE, IN46804		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
IAU	Findings include 1. On 08/04/11 a was observed searchair in the hallw was pushed into at 10:20 A.M. S wheelchair in the until 10:55 A.M. staff to the assist resident was not or toileted. At 12 Resident #C was Broda chair in the She remained in 1:22 P.M., when her in bed and chair besident #C's callindicated she was person physical and indicated the was person physical and indicate the search wheelchair besident was person physical and indicate the search wheelchair besident was person physical and indicated the was person physical and indicat	t 9:20 A.M., Resident #C ated in a Broda reclining vay near her room. She the doorway of her room he remained in her e doorway to her room, when she was taken by ed dining room. The checked for incontinence 2:25 P.M., on 08/04/11, observed back in her e doorway to her room. her Broda chair until CNA's #3 and #6 placed langed her brief. She was cord was reviewed p.m. Resident C's ed but were not limited high blood pressure and re plan, dated 3/2011, as to be toileted with a two assist, but the care plan he frequency.		IAU	inserviced on including specific continence management plans methods of transfer on care pl IDT will monitor compliance routine rounds. Results of audits will b forwarded to QA&A for tracking and trending monthly times 3 month then quarterly thereafter.	and ans. during e	DATE

000476

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155446	B. WIN			08/05/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	ę.		5700 W	ILKIE DRIVE		
		LTH AND REHABILITATION CEN	TER		VAYNE, IN46804		
(X4) ID		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION OF A CH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	•		+	TAG	BLI ICILIACI)		DATE
	1	quently come out into the					
	1	urse's station and request					
	1	r roommate, Resident #D.					
		nained in her wheelchair					
	beside her bed u	ntil 7:53 P.M., when she					
	was transferred b	by four staff into her bed,					
	CNA #5 and 8, a	and LPN #10 and 12.					
	Resident #D's re	cord was reviewed					
		a.m. Resident #D's					
		led but were not limited to					
	~	and seizure disorder.					
	diabetes, stroke,	and seizure disorder.					
	Resident #D's ca	are plan, dated 8/2011,					
	indicated she wa	s to be toileted with a two					
	person physical	assist, but the care plan					
	1	the frequency or that a					
		anical) was to be used.					
		at 7:00 P.M., Resident #H					
	was observed in	her wheelchair beside her					
	bed. CNA #8 wa	as noted to be in the room					
	changing the bed	l linens. Resident #H was					
	heard requesting	to go to bed. She					
	indicated she wa	s hurting because she had					
	1	ong (in her wheelchair).					
	1	esident #H was noted to					
	be her bed.						
	Interview with C	CNA #8 on 08/03/11 at					
	10:00 P.M., indi	cated she had toileted					
	1	ore supper about 5:30					
	1	got her up from bed. She					
	1	ident had not been					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION . DUM DIVIS 00			(X3) DATE SURVEY COMPLETED		
11112 12111	or confidence.	155446	A. BUII			08/05/20	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L	5700 WILKIE DRIVE				
COVING	TON MANOR HEAL	TH AND REHABILITATION CENT					
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
IAG		·		IAG	BEIGHNOT		DATE
	was placed in be	or incontinence until she					
	was placed iii be	u.					
	Resident #H's red	cord was reviewed					
		p.m. Resident #H's					
		ed but were not limited to					
	dementia, osteoa						
	Osteoporosis.	,					
	•						
	Resident #H's car	re plan, dated 7/2011,					
	indicated she was	s to be toileted with a two					
	person physical a	assist, but the care plan					
	did not indicate t	the frequency or that a					
	Hoyer lift was to	be used.					
		0/5/0011 + 11 00					
		on 8/5/2011 at 11:20					
	· ·	or of Nursing indicated					
	•	ms the facility was using					
	was working on	e enough and the facility					
	was working on	changes.					
	3.1-35(a)						
	3.1 33(u)						
							[
F0282		ided or arranged by the ovided by qualified persons					
SS=E		n each resident's written					
	plan of care.						
	Based on observa	ation, record review, and	F0	282	F 282	_	08/30/2011
		acility failed to ensure			1. Resident's I, K, G, F, C, I and H have been reviewed and I		
	_	regarding toileting and			not experienced any negative	nuve	
		eds were followed for 8 of			outcome.		
	-	idents. (Resident #I, K,			2. All residents have been		
	E, G, F, C, D, an	dH)			reviewed to ensure specific toile and incontinence needs are bein		
					and meonumence needs are belli	5	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SI		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		155446	B. WIN	IG		08/05/20	11
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
00/4/10	TON MANIOR LIEAL	THE AND DELIABILITATION OF N	TED	1	ILKIE DRIVE		
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	IER	FORT	VAYNE, IN46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	re	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG			DATE
	Findings include:	:			followed with no negative outco noted.	ome	
					3. Nursing staff will be inser	viced	
		was observed on 08/03/11			on the importance of implement		
		ng in her bed asleep. The			and following continence		
	resident remained	d in her bed from 7:00			management plans developed for		
	P.M 11:04 P.M	I., and was not checked			each resident. Nursing supervis		
	for incontinence	or offered toileting.			will monitor compliance 5x weether through unit rounds.	ekly	
	On 00/04/11 at 0	·20 A.M. Dagidant #I			Results of audits will be		
		:20 A.M., Resident #I			forwarded to QA&A for		
		n the main lounge at a			tracking and trending		
		service. Resident #I			monthly times 3 months		
		nain lounge until 11:21			then quarterly thereafter	·	
	•	Beautician, whose shop					
		cent to the main lounge,					
	indicated the resi	dent was taken from the					
	main lounge to th	ne dining room by					
	activity staff.						
	At 1:12 P.M., CN	NA #6 was noted to assist					
	-	d. Interview with CNA					
	#6, at this time. in	ndicated the resident was					
		sfer and she was to be					
	-	nged. She indicated she					
		lent when she put her to					
	•	not offer to toilet the					
	resident.	not offer to toffet the					
	restaett.						
	The clinical reco	rd for Resident #I was					
		04/11 at 2:00 P.M. The					
		mum Data Set (MDS)					
		pleted on 07/17/11,					
	indicated Resider	•					
		r bowels and bladder and					
		re staff assistance for					
	required extensiv	e stall assistance for					

000476

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155446		A. BU	ILDING	NSTRUCTION 00	CON	TE SURVEY MPLETED 5/2011	
	PROVIDER OR SUPPLIER		B. WII	5700 W	DDRESS, CITY, STATE, ZIP COE ILKIE DRIVE VAYNE, IN46804		
	SUMMARY S (EACH DEFICIEN REGULATORY OR toileting needs. Review of the cu Resident #I, curr indicated the resi assist to transfer for incontinence 2. Resident #K v at 7:00 P.M., sea chair by the nurs was noted to be a out of her chair. and #12 pushed I changed her and From 7:27 - 11:0 remained in her i not checked for i Interview with C 10:00 P.M., indic been in bed in the checked for inco- her up for supper	TH AND REHABILITATION CENTATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) Trent health care plan for ent through 09/11, dent was a one person and was to be checked every two hours. Was observed on 08/03/11 ted in a reclining Broda e's station. The resident actively trying to get up At 7:27 P.M., LPN's #10 Resident #K to her room, put her to bed. 4 P.M., Resident #K Froom in her bed. She was incontinence. NA #5, on 08/03/11 at cated Resident #K had the afternoon and had been intinence prior to getting	ITER	5700 W	ILKIE DRIVE	CTION JLD BE	(X5) COMPLETION DATE
	Broda chair by the The resident rem chair from 9:20	ne nurse's station asleep. ained in her reclining A.M 10:55 A.M., when by CNA #3 to the assisted					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155446		A. BU	ILDING	NSTRUCTION 00	(X3) DATE COMP: 08/05/2	LETED	
	PROVIDER OR SUPPLIER		B. WI	5700 W	DDRESS, CITY, STATE, ZIP CODE ILKIE DRIVE VAYNE, IN46804	1 00/00/1	
			· · · · · ·	<u> </u>			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5)
PREFIX TAG	` ·	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION DATE
1110		CNA #3 put Resident #K	+	1110			BITTE
		ged her incontinence brief.					
	to oca and chang	ged her incommence orier.					
	The clinical reco	ord for Resident #K was					
		04/11 at 10:00 A.M. The					
		S assessment for Resident					
		n 07/05/11, indicated the					
		l extensive staff assistance					
	•	ng needs, and was always					
		er bladder and frequently					
	incontinent of he	1 2					
	incontinent of he	of bowers.					
	The current healt	th care plans for Resident					
		gh 11/11, indicated the					
		two staff for transferring					
	_	ds and was to be checked					
		every two hours.					
	101 incontinence	every two nours.					
	3. On 08/04/11 a	at 9:20 A.M., Resident					
	#G was observed	d seated in her wheelchair					
	across from the r	nurse's station. The					
	resident indicate	d she needed help					
	because she was	afraid of people trying to					
	"get her." LPN #	#9 was alerted and					
	reassured and tal	ked with Resident # G.					
	Resident #G rem	ained in her wheelchair					
	across from the r	nurse's station from 9:20 -					
	11:09 A.M. At 1	1:09 A.M., LPN #9					
		#G to the assisted dining					
	-	not toileted or offered to					
	be changed prior	to going to the dining					
	room.						
	At 12:25 P.M., o	on 08/04/11, Resident #G					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155446	B. WIN		-	08/05/2	011
		<u> </u>	P. 1121		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ILKIE DRIVE		
COVING	TON MANOR HEA	LTH AND REHABILITATION CEN	TER	1	VAYNE, IN46804		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	ICY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ΓE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		in her wheelchair in the					
	main lounge, aw	ake, watching television.					
	At 1:25 P.M., LI	PN #9 pushed Resident					
	#G from the mai	n lounge to her room and					
	left her in her wh	neelchair beside her bed.					
	At 2:00 P.M., Cl	NA's #3 and #6					
	transferred Resid	dent #G to her bed and					
	changed the resid	dent. Resident #G's brief					
	was wet, there w	vere scars from previous					
	1	he resident skin was not					
	open.						
	open.						
	Interview with I	PN #10 during the initial					
		ty, conducted on 08/03/11					
		licated Resident #G was					
	1	er bowels and bladder,					
		·					
	1 -	of a mechanical lift for					
	1	d an open area of her					
	bottom.						
	Trl1: 1	1 C D11					
		ord for Resident #G was					
		05/11 at 9:30 A.M. The					
		S assessment for Resident					
	1 1	n 06/09/11, indicated the					
	1	l extensive staff assistance					
	of two for transf	erring and toileting needs					
	and was frequen	tly (more than seven					
	incontinent episo	odes in seven days)					
	incontinent of he	er bladder and					
	occasionally inco	ontinent of her bowels.					
	The current heal	th care plan for Resident					
	1	ugh 09/11, indicated since					
	1	idents toileting needs					
	1 55/51/11 the resi	active terroring needs					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SU	RVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLET	ED
		155446	B. WIN			08/05/201	1
			D. 1111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	-			ILKIE DRIVE		
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	ITER	1	WAYNE, IN46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE (COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	were for "Inconti	nence Management" and					
	the resident was	to be checked every two					
	hours, the care pl	lan also indicated the					
	resident was to b	e transferred with a					
	mechanical lift.						
	 4 Resident #F 13	vas observed on 08/03/11					
		ng in her bed. She					
	I	_					
		ped, from 7:00 P.M					
	l '	no staff were noted to					
	*	ontinence care for					
	Resident #F. Into	erview with CNA #8, on					
	08/03/11 at 7:00	P.M., indicated Resident					
	#F had been in be	ed when she started her					
	shift and she had	been checked and					
	changed before s	he was gotten up for					
	supper.	2 1					
	заррет.						
	On 08/04/11 at 9	:20 A.M., Resident #F					
		ng in a reclining Broda					
		the nurse's station. She					
		Broda chair asleep from					
		5 A.M. At 10:45 A.M.,					
		nursing staff members					
		reposition and pull the					
	resident up in the	Broda chair. At 11:04					
	A.M., CNA #3 pt	ushed Resident #F to the					
	assisted dining ro	oom. She was not					
	checked for incom	ntinence or toileted.					
	On 08/04/11 at 1	2:25 P.M., Resident #F					
		Il in her Broda chair by					
		n in the hallway. At 1:00					
		·					
	r.ivi., CINA'S #3	and #6 transferred					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155446			LDING	NSTRUCTION 00	(X3) DATE : COMPL 08/05/2	ETED	
NAME OF			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIEI				ILKIE DRIVE		
COVING	TON MANOR HEA	LTH AND REHABILITATION CEN	ITER	FORT V	VAYNE, IN46804		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	ŧ	n her reclining chair to					
	her bed with a mechanical lift. The						
	resident's brief v	vas changed and the					
	resident was not						
		oth her bladder and					
	bowels.						
	The clinical room	ord for Resident #F was					
		04/11 at 10:35 A.M. The					
		S assessment for Resident					
		on 06/30/11, indicated the					
	_	rays incontinent of her					
	bowels and blad	der and required					
	extensive staff a	ssistance of two for					
	toileting needs.						
	The current heel	th care plan for Decident					
		th care plan for Resident 19,000 plan for Resi					
	1 '	to receive "Incontinence					
		nd was to be checked					
	-	(for incontinence).					
		,					
	5. On 08/04/11	at 9:20 A.M., Resident #E					
	was noted to be	in his wheelchair in the					
		n activity. He remained					
		ge from 9:20 - 11:20					
		A.M., CNA #6 put his					
	_	heelchair pedals and					
	1 ~	ctly to the dining room.					
		s not toileted or checked					
	for incontinence.						
	On 08/04/11 from	m 12:25 P.M 12:40					
		E was noted to be					

		X1) PROVIDER/SUPPLIER/CLIA	I			(X3) DATE	SURVEY	
		IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPI		
		155446	B. WIN			08/05/2	2011	
NAME OF I	PROVIDER OR SUPPLIER	3	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•		
					/ILKIE DRIVE			
COVING	TON MANOR HEA	LTH AND REHABILITATION CEN	ΓER	FORT	WAYNE, IN46804			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTIO		(X5) COMPLETION	
PREFIX TAG		(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP			
IAG		·	+	IAG	BERGEROLY		DATE	
	visiting with family members. At 1:30							
	P.M., Resident #E was transferred by CNA's #3 and #6 from the wheelchair into							
		ident's brief was wet and						
	1	t smear of bowel						
	movement noted	l.						
	771 1:	1 C D1 // // // // // // // // // // // //						
		ord for Resident #E was						
		04/11 at 1:05 P.M. The						
		S assessment for Resident						
	_	n 07/29/11, indicated the						
		l extensive staff assistance						
		ng needs, and was totally						
		s bladder and frequently						
	incontinent of hi	s bowels.						
	Th	41 1						
		th care plans, current as						
		ed the resident required						
		e Management" program						
		ecked every two hours						
	for incontinence							
		at 9:20 A.M., Resident						
		d seated in a Broda						
	1	n the hallway near her						
		placed in the doorway of						
		0 A.M. She remained in						
		n the doorway to her						
		5 A.M., when she was						
	1 -	the assisted dining room.						
	The resident was not checked for							
	incontinence or	toileted. At 12:25 P.M.,						
	on 08/04/11, Res	sident #C was observed						
	back in her Brod	la chair in the doorway to						
	her room. She re	emained in her Broda						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155446	A. BUI	LDING	00	COMPI		
		155446	B. WIN			08/05/2	1011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
COMPIC	TON MANOD HEAL	TH AND REHABILITATION CEN	ITED	1	ILKIE DRIVE		
			NIEK	FORTV	VAYNE, IN46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
IAG			+	IAG	BETTELLINETY		DATE
		P.M., when CNA's #3 and					
		bed and changed her					
	brief. She was n	ot tolleted.					
	Desident // Classi	1					
	Resident # C's clinical record was reviewed 8/4/2011 at 1:45 p.m. Resident #C's diagnoses included but were not limited to; heart failure, high blood						
	pressure and oste	coporosis.					
	Resident #C's care plan dated 3/2011						
		s to be toileted with a two					
		assist, but the care plan					
	did not indicate t	he frequency.					
	Resident #C's M	inimum Data Set, dated					
		ed she was extensive					
	· ·	oileting and needed two					
	person physical a						
	person physical c	issistance.					
	7. Resident #D v	was observed on 08/03/11					
	at 7:00 P.M., sea	ted in her room in her					
	wheelchair besid	e her bed. Her					
	roommate, alert a	and oriented Resident #S,					
	was noted to free	quently come out into the					
	1	irse's station and request					
	1 *	r roommate, Resident #D.					
		ained in her wheelchair					
	beside her bed ur	ntil 7:53 P.M. when she					
	was transferred b	by four staff into her bed,					
		and LPN's #10 and 12.					
	,						
	Resident #D's bu	ttocks was noted to be					
	bright red and sh	e had an open area on her					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155446		ľ	IULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPI	LETED	
		155446	B. WIN	IG		08/05/2	011
	PROVIDER OR SUPPLIER			5700 W	ADDRESS, CITY, STATE, ZIP CODE ILKIE DRIVE		
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	NTER	FORT V	VAYNE, IN46804		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION) cks, and she had been		TAG	DEFICIENC!)		DATE
	• 11	·					
	Interview with CNA #8, on 08/03/11 at 10:00 P.M., indicated Resident #D had been transferred to her bed the previous evening by ambulance staff after having been readmitted from an acute care center to the facility. She indicated she was unable to toilet and/or check the resident prior to 7:53 P.M., when she was observed being transferred to her bed because she needed assistance and was unsure of the method going to be utilized to transfer Resident #D. Interview on 8/3/2011 at 7:35 P.M., with Resident #D and her roommate, Resident #S, indicated she had not been toileted since she had received a shower around 10:30 A.M.						
	was changed and wheelchair by Cl	0:00 A.M., Resident #D transferred to her NA's #3 and #6. She					
		wheelchair in the hallway					
		until 11:12 A.M., when					
		the shower room by					
		eighed in her wheelchair.					
	She was then placed back by the telephone and the nurse's station on the						
	East unit. At approximately 11:20 A.M.,						
	Resident #D was pushed in her						
	wheelchair by LF	PN #9 to the dining room					

NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER TAG SUMMAYSTATEMENT OF EFFECTINCIES TAG REGULATORY OR LSC IDENTIFYING INFORMATION) FOR TURNER, IN46804 FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) FOR Lunch. She was not toileted or checked for incontinence prior to being taken to the dining room. On 08/04/11 at 12:25 P.M., Resident #D was again in her wheelchair in the hallway by the nurse's station. At 1:12 P.M., LPN #9 pushed Resident #D back to her room to braid her hair. She was immediately placed back out in the hallway by the nurse's station after her hair was braided. She was not toileted. At 2:00 P.M., Resident #D remained in her wheelchair in the hallway across from the nurse's station. Resident #D remained in her wheelchair in the hallway across from the nurse's station. Resident #D indicated her husband was picking her up to go to her grandson's birthday party around 2:00 P.M. Resident #D's diagnoses included but were not limited to diabetes, stroke, and scizure disorder. Resident #D's care plan, dated 8/2011, indicated she was to be toileted with a two person physical assist, but the care plan did not indicate the frequency or that a Hoyer lift was to be used. Resident #D's Minimum Data Set, dated 7/20/2011, indicated she was extensive assistance with toileting and needed two			(X1) PROVIDER/SUPPLIER/CLIA	(X2)	MULTIPLE CO			(X3) DATE	
STRIET ADDRESS, CITY, STATE, APPCODE 5700 WILKE DRIVE FORT WAYNE, INASB04 SUMMARY STATEMENT OF DEBUCINCEIN FREEN GEACH DEFICIENCY MUST BE PRECEDED BY PULL FREEN TAG For lunch. She was not toileted or checked for incontinence prior to being taken to the dining room. On 08/04/11 at 12:25 P.M., Resident #D was again in her wheelchair by the nurse's station. At 1:12 P.M., LPN #9 pushed Resident #D back to her room to braid her hair. She was immediately placed back out in the hallway by the nurse's station after her hair was braided. She was not toileted. At 2:00 P.M., Resident #D remained in her wheelchair in the hallway across from the nurse's station after her hair was praided when to be regarded to be regrandson's birthday party around 2:00 P.M. Resident #D was not toileted prior to leaving for the party at 2:10 P.M. Resident #D's record was reviewed 8/5/2011 at 8:10 a.m. Resident #D's diagnoses included but were not limited to diabetes, stroke, and seizure disorder. Resident #D's care plan, dated 8/2011, indicated she was to be toileted with a two person physical assist, but the care plan did not indicate the frequency or that a Hoyer lift was to be used. Resident #D's Minimum Data Set, dated 7/20/2011, indicated she was extensive assistance with toileting and needed two	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BI	UILDING	00			
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diabetes, stroke, and seizure disorder. Resident #D's care plan, dated 8/2011, indicated she was to be toileted with a two person physical assist, but the care plan did not indicate the frequency or that a Hoyer lift was to be used. Resident #D's Minimum Data Set, dated 7/20/2011, indicated she was extensive assistance with toileting and needed two		8/5/2011 at 8:10	a.m. Resident #D's						
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person physical assist, but the care plan did not indicate the frequency or that a Hoyer lift was to be used. Resident #D's Minimum Data Set, dated 7/20/2011, indicated she was extensive assistance with toileting and needed two		Resident #D's car	re plan, dated 8/2011,						
did not indicate the frequency or that a Hoyer lift was to be used. Resident #D's Minimum Data Set, dated 7/20/2011, indicated she was extensive assistance with toileting and needed two		indicated she was	s to be toileted with a two						
did not indicate the frequency or that a Hoyer lift was to be used. Resident #D's Minimum Data Set, dated 7/20/2011, indicated she was extensive assistance with toileting and needed two		person physical a	assist, but the care plan						
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Resident #D's Minimum Data Set, dated 7/20/2011, indicated she was extensive assistance with toileting and needed two									
7/20/2011, indicated she was extensive assistance with toileting and needed two		J							
7/20/2011, indicated she was extensive assistance with toileting and needed two		Resident #D's Mi	inimum Data Set. dated						
assistance with toileting and needed two									
		· ·							
	EODW CWe 3		-	<u> </u> 7VIW1	4 Facility I	D: 000476	If continuation sh	naat D-	no 15 of 47

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155446			IULTIPLE CO LDING	NSTRUCTION 00	COMPL	ETED	
		155446	B. WIN			08/05/2	011
NAME OF I	PROVIDER OR SUPPLIEI	₹		1	ADDRESS, CITY, STATE, ZIP CODE		
COVING	TON MANOR HEA	LTH AND REHABILITATION CEN	NTER	1	ILKIE DRIVE VAYNE, IN46804		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	person physical	assistance.					
	8. On 08/03/11 at 7:00 P.M., Resident #H was observed in her wheelchair beside her bed. CNA #8 was noted to be in the room changing the bed linens. Resident #H was heard requesting to go to bed. She indicated she was hurting because she had been sitting so long (in her wheelchair). At 7:35 P.M., Resident #H was noted to be her bed. Interview with CNA #8 on 08/03/11 at						
		CNA #8 on 08/03/11 at cated she had toileted					
		ore supper about 5:30					
		got her up from bed. She					
		ident had not been					
		or incontinence until she					
	was placed in be						
	_						
	Resident #H's re	cord was reviewed					
		p.m. Resident #H's					
	"	led but were not limited to					
	dementia, osteoa	orthritis, and					
	Osteoporosis.						
	Resident #U's os	are plan, dated 7/2011,					
		us to be toileted with a two					
		assist, but the care plan					
		the frequency or that a					
	Hoyer lift was to						
	Resident #H's Minimum Data Set						
	assessment, date	ed 7/15/2011, indicated					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/30/2011 FORM APPROVED OMB NO. 0938-0391

l	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155446			MULTIPLE CO JILDING NG	NSTRUCTION 00	С	OATE SURVEY OMPLETED /05/2011
	PROVIDER OR SUPPLIER	TH AND REHABILITATION CEN	ITER	5700 W	DDRESS, CITY, STATE, ZIP C ILKIE DRIVE VAYNE, IN46804	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
TAG	she was extensiv toileting and nee assistance.	e assistance with ded two person physical relates to Complaint		TAG	DEFICIENCY		DATE

000476

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155446	B. WIN			08/05/2	011
			В. WПV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			l	VILKIE DRIVE		
COVING	TON MANOR HEAL	TH AND REHABILITATION CENT	ER	1	WAYNE, IN46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX (E CRC		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)			DEFICIENCY)		DATE
F0312 SS=E	to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interviews, the facility failed to provide toileting and/or incontinence care for 8		F0	312	F 312 1. Resident's I, K, G, F, C, I H have been reviewed and have experienced any negative outcome.	e not	08/30/2011
	•				2. All residents have been		
	•	nts in a sample of 11.			reviewed to ensure specific toil	_	
	(Resident C, D, H	E, F, G, H, I, and K)			and incontinence needs are being	-	
	Findings includes		noted. 3. Nursing		3. Nursing staff will be insert on the importance of implement	sing staff will be inserviced portance of implementing	
		as observed on 08/03/11			and following continence		
		ng in her bed asleep. The			management plans developed for		
	resident remained	d in her bed from 7:00			each resident. Nursing supervi		
	P.M 11:04 P.M	I. and was not checked			will monitor compliance 5x we through unit rounds.	екту	
	for incontinence	or offered toileting. At			4. Results of audits will be		
	10:10 P.M., CNA	A's #5 and #8 had left			forwarded to QA&A for tracking	ng and	
	and there was on	ly one CNA left working			trending monthly times 3 mont	hs	
		A #11 indicated she			then quarterly thereafter.		
		til 12:00 midnight when					
	another CNA can	_					
		m to morn.					
	was noted to be in Catholic church so remained in the remained in the remained adjacent to the control of the c	:20 A.M., Resident #I In the main lounge at a service. Resident #I main lounge until 11:21 Beautician, whose shop cent to the main lounge, dent was taken from the me dining room by					
					1		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155446			IULTIPLE COI ILDING	NSTRUCTION 00		PLETED	
		155446	B. WIN	NG		08/05/	2011
	PROVIDER OR SUPPLIER TON MANOR HEAL	TH AND REHABILITATION CEN	ITER	5700 W	.DDRESS, CITY, STATE, ZIP CODE ILKIE DRIVE VAYNE, IN46804		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRODEFICIENCY)	BE	(X5) COMPLETION DATE
	Resident #I to be #6 indicated the resident when she did not offer to to CNA indicated R incontinent of he The clinical recordinated recordinated Resident when the clinical recordinated Resident incontinent of he required extensive toileting needs. Review of the current Resident #I, current indicated the resident #I, current indicated #I	rd for Resident #I was 04/11 at 2:00 P.M. The mum Data Set (MDS) pleted on 07/17/11, at #I was always r bowels and bladder and re staff assistance for rrent health care plan for ent through 09/11, dent was a one person and was to bed checked every two hours. was observed on 08/03/11 ted in a reclining Broda e's station. The resident actively trying to get up At 7:27 P.M., LPN's #10 Resident #K to her room,					

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU COMPLE		
ANDILAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155446		- 1	LDING	00	08/05/20	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				ILKIE DRIVE		
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	NTER	FORT V	VAYNE, IN46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION DATE
1710		room in her bed. She was		1110			DATE
	not checked for i						
	Interview with CNA #5, on 08/03/11 at 10:00 P.M. indicated Resident #K had been in bed in the afternoon and had been checked for incontinence prior to getting her up for supper.						
	nei up ioi suppei						
	On 08/04/11 at 9	:20 A.M., Resident #K					
		nted in her reclining					
	Broda chair by th	ne nurse's station asleep.					
	The resident rem	ained in her reclining					
	chair from 9:20 A	A.M 10:55 A.M., when					
	she was taken by	CNA #3 to the assisted					
	dining room for l	lunch.					
	At 12:20 P.M., C	CNA #3 put Resident #K					
	·	ged her incontinence brief.					
	Resident #K was	observed on 8/5/11 at					
		iving incontinence care.					
		turated. Her skin was					
	pink and intact.	aracea. Tree 5km was					
		rd for Resident #K was					
		04/11 at 10:00 A.M. The					
		S assessment for Resident					
	#K, completed on 07/05/11, indicated the						
	_	extensive staff assistance					
		ng needs, and was always					
		r bladder and frequently					
	incontinent of he	er bowels.					

		X1) PROVIDER/SUPPLIER/CLI	(X2	2) MULTIPLE CO			X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. I	BUILDING	00		COMPL	
		155446	В. V	WING			08/05/2	U11
NAME OF F	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STA	ATE, ZIP CODE		
					ILKIE DRIVE			
COVING	TON MANOR HEAL	TH AND REHABILITATION	ON CENTER	FORT W	VAYNE, IN4680	4		
(X4) ID		TATEMENT OF DEFICIENCIES		ID		PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY F	I .	PREFIX	CROSS-REFERENC	VE ACTION SHOULD BE ED TO THE APPROPRIATI	E	COMPLETION
TAG		LSC IDENTIFYING INFORMAT		TAG	DEF	FICIENCY)		DATE
		th care plans for Reside	nt					
		gh 11/11, indicated the						
	•	two staff for transferri	· 1					
	_	ds and was to be check	ed					
	for incontinence every two hours.							
		at 9:20 A.M., Resident	.					
	#G was observed seated in her wheelchair							
		nurse's station. The						
		d she needed help						
		afraid of people trying	to					
	"get her." LPN #9 was alerted and							
		ked with Resident #G.						
		ained in her wheelchair						
		nurse's station from 9:20	0 -					
	11:09 A.M. At 1	1:09 A.M., LPN #9						
	pushed Resident	#G to the assisted dinir	ng					
		not toileted or offered to						
	be changed prior	to going to the dining						
	room.							
	At 12:25 P.M.,or	n 08/04/11, Resident #C	j					
	was noted to be i	n her wheelchair in the						
	main lounge, awa	ake, watching television	n.					
		N #9 pushed Resident						
	#G from the main	n lounge to her room ar	nd					
	left her in her wh	neelchair beside her bed	l.					
	At 2:00 P.M., CN	NA's #3 and #6						
	transferred Resid	lent #G to her bed and						
	changed the resid	dent. Resident #G's bri	ef					
	_	ere scars from previous	I .					
		he resident's skin was n	I .					
	•	ear macerated. CNA #6	I .					
		nt #G had recently had	I .					
FORM CMS-2	567(02-99) Previous Versio	-	at ID: 7VIW	11 Facility I	D: 000476	If continuation sh	eet Pac	ae 21 of 47

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155446		A. BUI	ILDING	NSTRUCTION 00	(X3) DATE COMP 08/05/ 2	LETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE LKIE DRIVE /AYNE, IN46804		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
		buttocks and did not like					
	tour of the facilit at 8:10 P.M. indi incontinent of he required the use	PN #10 during the initial by, conducted on 08/03/11 cated Resident #G was by bowels and bladder, of a mechanical lift for d an open area of her					
	reviewed on 08/0 most recent MD9 #G, completed o resident required of two for transfe and was frequent incontinence wit incontinent of he						
	#G, current throu 03/31/11, the res were for "Incont the resident was hours. The care president was to be mechanical lift. 4. Resident #F v	th care plan for Resident 19h 09/11, indicated since 19h 19/11, indicated s					
	· ·	ng in her bed. She bed, from 7:00 P.M					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155446		A. BU	ILDING	NSTRUCTION 00	ľ	E SURVEY PLETED /2011	
	PROVIDER OR SUPPLIER		•	5700 W	DDRESS, CITY, STATE, ZIP CO ILKIE DRIVE VAYNE, IN46804		
	SUMMARY S (EACH DEFICIEN REGULATORY OR 11:04 P.M., and is perform any inco Resident #F. Into 08/03/11 at 7:00 #F had been in be shift and she had changed before s supper. On 08/04/11 at 9 was observed lyichair across from remained in the If 9:20 A.M 10:4 two unidentified were observed to resident up in the A.M., CNA #3 p assisted dining re checked for inco On 08/04/11 at 1 was observed still the nurse's station P.M., CNA's #3 Resident F from bed with a mecha brief was change	TH AND REHABILITATION CENTATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) The staff were noted to serview with CNA #8, on P.M., indicated Resident ed when she started her been checked and he was gotten up for 1.20 A.M., Resident #F Ing in a reclining Broda at the nurse's station. She Broda chair asleep from 5 A.M. At 10:45 A.M., nursing staff members reposition and pull the Broda chair. At 11:04 ashed Resident #F to the form. She was not entinence or toileted. 2.25 P.M., Resident #F I in her Broda chair by an in the hallway. At 1:00 and #6 transferred ther reclining chair to her enical lift. The resident's dand the resident was	JTER	5700 W	ILKIE DRIVE	DDE RECTION OULD BE	(X5) COMPLETION DATE
	bladder and bow indentations on t the brief had bee	en incontinent of both her els. There were deep the resident's skin where n. Resident #F's skin was or with no open areas.					

000476

		X1) PROVIDER/SUPPLIER/CLL	A (X2)	MULTIPLE CO			(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00		COMPL	
		155446	B. W	ING			08/05/2	U11
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
				1	ILKIE DRIVE			
COVING	TON MANOR HEAL	TH AND REHABILITATIO	N CENTER	FORT W	VAYNE, IN46804	1		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S P	LAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FU		PREFIX	CROSS-REFERENCE	E ACTION SHOULD BE ED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATI	ON)	TAG	DEFI	ICIENCY)		DATE
		rd for Resident #F was						
		04/11 at 10:35 A.M. Th						
		S assessment for Reside	I					
	-	on $06/30/11$, indicated the	ne					
		ays incontinent of her						
	bowels and bladder and required							
extensive staff assistance of two for								
toileting needs.								
tolicing liceus.								
	The current healt	th care plan for Residen	t					
#F, current through 09/03/11, indicated								
	the resident was to receive "Incontinence							
	Management" and was to be checked							
	every two hours	(for incontinence).						
	5. On 08/04/11 a	at 9:20 A.M., Resident #	ŧΕ					
	was noted to be i	n his wheelchair in the						
	main lounge at a	n activity. He remained	1					
	_	ge from 9:20 - 11:20						
	`	A.M., CNA #6 put his						
		neelchair pedals and						
	•	etly to the dining room.						
	*	not toileted or checked						
	for incontinence.							
	101 meonunciice.							
	 On 08/04/11 from	n 12:25 P.M 12:40						
		E was noted to be						
	f .	aily members. At 1:30						
	-	E was transferred by						
		from the wheelchair in	to					
		ident's brief was wet an	I					
			ı					
	there was a slight							
	movement noted. In addition, there were		l l					
	large deep indent	tations from the brief an	ia					
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event	ID: 7VIW1	1 Facility I	D: 000476	If continuation sh	eet Pa	ge 24 of 47

STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155446	B. WIN			08/05/2	011
NAME OF I	DROVIDED OD GUDDI IED		!	STREET A	ADDRESS, CITY, STATE, ZIP CODE	!	
NAME OF F	PROVIDER OR SUPPLIER			5700 W	/ILKIE DRIVE		
	TON MANOR HEAL	TH AND REHABILITATION CEN	NTER	FORT \	WAYNE, IN46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
IAG		· · · · · · · · · · · · · · · · · · ·	-	IAU			DATE
	posterior upper the	resident's buttocks and					
	posterior upper ti	ingii.					
	The clinical reco	rd for Resident #E was					
	reviewed on 08/04/11 at 1:05 P.M. The most recent MDS assessment for Resident						
		n 07/29/11, indicated the					
	l • •	extensive staff assistance					
		ng needs, and was totally					
		s bladder and frequently					
	incontinent of his						
		5 00WCIS.					
	The current healt	th care plans, current as					
		ed the resident required an					
		anagement" program and					
		ed every two hours for					
	incontinence.	www.very envoluence for					
		at 9:20 A.M., Resident					
		I seated in a Broda					
		the hallway near her					
	_	placed in the doorway of					
	_	0 A.M. She remained in					
		the doorway to her					
		5 A.M., when she was					
		o the assisted dining					
	^	ent was not checked for					
		oileted. At 12:25 P.M.,					
		sident #C was observed					
	· ·	a chair in the doorway to					
		emained in her Broda					
		P.M., when CNA's #3 and					
		bed and changed her					
	_	dicated Resident #C's					
		ed. She was not toileted.					
					!		

000476

NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Resident # C's record was reviewed 8/4/2011 at 1:45 p.m. Resident #C's diagnoses included but were not limited to; heart failure, high blood pressure and osteoporosis. Resident #C's care plan, dated 3/2011, indicated she was to be toileted with a two person physical assist, but the care plan did not indicate the frequency. Resident #C's Minimum Data Set, dated 6/7/2011, indicated she was extensive assistance with toileting and needed two person physical assistance. 7. Resident #D was observed on 08/03/11	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155446		Ì	ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
COVINGTON MANOR HEALTH AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG Resident # C's record was reviewed 8/4/2011 at 1:45 p.m. Resident #C's diagnoses included but were not limited to; heart failure, high blood pressure and osteoporosis. Resident # C's care plan, dated 3/2011, indicated she was to be toileted with a two person physical assist, but the care plan did not indicate the frequency. Resident # C's Minimum Data Set, dated 6/7/2011, indicated she was extensive assistance with toileting and needed two person physical assistance. 7. Resident # D was observed on 08/03/11			100440	B. WIN			06/05/2	011
COVINGTON MANOR HEALTH AND REHABILITATION CENTER (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Resident # C's record was reviewed 8/4/2011 at 1:45 p.m. Resident #C's diagnoses included but were not limited to; heart failure, high blood pressure and osteoporosis. Resident #C's care plan, dated 3/2011, indicated she was to be toileted with a two person physical assist, but the care plan did not indicate the frequency. Resident #C's Minimum Data Set, dated 6/7/2011, indicated she was extensive assistance with toileting and needed two person physical assistance. 7. Resident #D was observed on 08/03/11	NAME OF P	ROVIDER OR SUPPLIER						
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did not indicate the frequency. Resident #C's Minimum Data Set, dated 6/7/2011, indicated she was extensive assistance with toileting and needed two person physical assistance. 7. Resident #D was observed on 08/03/11			•					
Resident #C's Minimum Data Set, dated 6/7/2011, indicated she was extensive assistance with toileting and needed two person physical assistance. 7. Resident #D was observed on 08/03/11		person physical a	assist, but the care plan					
6/7/2011, indicated she was extensive assistance with toileting and needed two person physical assistance. 7. Resident #D was observed on 08/03/11		did not indicate ti	he frequency.					
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assistance with toileting and needed two person physical assistance. 7. Resident #D was observed on 08/03/11		Resident #C's Mi	inimum Data Set, dated					
person physical assistance. 7. Resident #D was observed on 08/03/11		6/7/2011, indicate	ed she was extensive					
7. Resident #D was observed on 08/03/11		assistance with to	oileting and needed two					
		person physical a	assistance.					
		7. Resident #D v	was observed on 08/03/11					
at 7:00 P.M., seated in her room in her		·						
wheelchair beside her bed. Her								
roommate, alert and oriented Resident #S,								
was noted to frequently come out into the								
hallway to the nurse's station and request		_	•					
assistance for her roommate, Resident #D.								
Resident #D remained in her wheelchair								
beside her bed until 7:53 P.M., when she								
was transferred by four staff members into			by four staff members into					
her bed.		ner bed.						
Resident #D was observed on 08/03/11 at		Resident #D was	observed on 08/03/11 at					
7:53 P.M., receiving incontinence care.								
The resident was noted to have an			C					
unfastened incontinence brief on and had								
been incontinent of bowel when she was								

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:			(X2) M	IULTIPLE CO	INSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155446	A. BUI	LDING	00	COMPL 08/05/2	
		100440	B. WIN			00/03/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	TER		VAYNE, IN46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	πE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		the wheelchair to her					
		t was noted to have an					
		cer on her upper right					
	buttock.						
	Resident #D's bu	ttocks were noted to be					
		e had a 4 centimeter by 3					
	_	area on her right upper					
	buttocks.	area on her right upper					
	outtoeks.						
	A Nursing Admis	ssion Assessment, dated					
	_	ed Resident #D had been					
	Í .	the hospital with the					
	open area on the	•					
	open area on the	outlocks.					
	Interview with C	NA #8, on 08/03/11 at					
		cated Resident #D had					
		to her bed the previous					
		llance staff after having					
		from an acute care center					
		he indicated she was					
		nd/or check the resident					
	prior to 7:53 P.M						
	•	ransferred to her bed					
	•	led assistance and was					
		thod going to be utilized					
	to transfer Reside	• •					
	Interview on 8/3/	2011 at 8:30 P.M., with					
		her roommate, Resident					
		had not been toileted					
		eived a shower around					
	10:30 A.M.						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE COMPL		
		155446	A. BUI B. WIN	LDING IG		08/05/2	011
NAME OF I	DROVIDED OD CLIDDLIED		P. 112		ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF I	PROVIDER OR SUPPLIER			1	ILKIE DRIVE		
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	ITER	FORT V	VAYNE, IN46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· `	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
IAG		0:00 A.M., Resident #D		IAG			DATE
		transferred to her					
		NA's #3 and #6. She					
	1	wheelchair in the hallway					
		until 11:12 A.M., when					
		the shower room by					
	CNA #13 and we	eighed in her wheelchair.					
	She was then pla	ced back out by the					
	1 ^	e nurse's station on the					
	1 **	roximately 11:20 A.M.,					
	Resident #D was	-					
	1	PN #9 to the dining room					
	for lunch. She w						
		ntinence prior to being					
	pushed to the din	ing room.					
	On 08/04/11 at 1	2:25 P.M., Resident #D					
		wheelchair by the nurse's					
		P.M., LPN #9 pushed					
	Resident #D bacl	k to her room to braid her					
	hair. She was im	mediately placed back					
		y by the nurse's station					
		s braided. She was not					
		P.M., Resident #D					
		wheelchair in the hallway					
		nurse's station. Resident					
	_	ked her up to go to her					
	~	lay party around 2:10					
	to leaving the fac	nt was not toileted prior					
	io leaving the lac	mity.					
	The clinical reco	rd for Resident #D was					
	reviewed on 08/0						
		agnoses included but					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155446	B. WIN			08/05/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				ILKIE DRIVE		
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	NTER	1	VAYNE, IN46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
	were not limited	to diabetes, stroke, and					
	seizure disorder.						
	 Resident #D's ca	re plan, dated 8/2011,					
		s to be toileted with a two					
		assist, but the care plan					
		he frequency or that a					
	l -	anical lift) was to be					
	used.						
	Resident #D's M	inimum Data Set, dated					
	7/20/2011, indica	ated she was extensive					
	assistance with to	oileting and needed two					
	person's physical	assistance.					
	8 On 08/03/11 a	at 7:00 P.M., Resident #H					
		her wheelchair beside her					
		as noted to be in the room					
		l linens. Resident #H was					
	, , ,	to go to bed. She					
		s hurting because she had					
		ong (in her wheelchair).					
	At 7:35 P.M., Re	esident #H was noted to					
	be her bed.						
	Interview with C	NA #8 on 08/03/11 at					
	10:00 P.M., indic	cated she had toileted					
		ore supper about 5:30					
		got her up from bed. She					
		ident had not been					
	_	r incontinence until she					
	was placed in be	a.					
	D 11 . //xx	1					
	Resident #H's red	cord was reviewed					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155446		ĺ	MULTIPLE CO JILDING ING	00	COMP: 08/05/2	LETED	
	PROVIDER OR SUPPLIER	.TH AND REHABILITATION CEN		STREET A 5700 W	DDRESS, CITY, STATE, ZIP CODE ILKIE DRIVE VAYNE, IN46804	I	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG	8/4/2011 at 1:00 diagnoses includ diabetes, stroke, On 8/5/2011 at 1 was observed on was noted to be stremoval. Her ski areas noted. Resident #H's ca indicated she was person physical add not indicate thoyer lift was to Resident #H's M 7/15/2011, indicated assistance with the persons physical	p.m. Resident #H's ed but were not limited to and seizure disorder. 1:10 A.M., perineal care Resident #H. Her brief saturated with urine on n was pink with no open re plan, dated 7/2011, s to be toileted with a two assist, but the care plan he frequency or that a be used. inimum Data Set, dated ated she was extensive polleting and needed two		TAG	DEFICIENCY)		DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155446	B. WING			08/05/2	011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
					ILKIE DRIVE		
COVING	TON MANOR HEAL	TH AND REHABILITATION CENTE	ΞR	FORT V	VAYNE, IN46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION) ave sufficient nursing staff		IAG	DEFICIENCI)		DATE
F0353 SS=E		and related services to					
33-E	•	the highest practicable					
	physical, mental, a	and psychosocial well-being					
	of each resident, as determined by resident assessments and individual plans of care.						
	The facility must p	rovide services by sufficient					
	numbers of each of	of the following types of					
	•	-hour basis to provide					
	nursing care to all with resident care	residents in accordance					
	with resident care	piaris.					
	Except when waiv	ed under paragraph (c) of					
		ed nurses and other					
	nursing personnel	•					
	Except when waiv	ed under paragraph (c) of					
		cility must designate a					
		serve as a charge nurse on					
	each tour of duty.		Ε0	252	F 353		00/20/2011
		ation, interview and	FU	353	1. Resident's C, D, E, F, G, I	ні	08/30/2011
		e facility failed to			and K have been reviewed and l		
		e staffing to meet the			not experienced any negative		
	-	f 8 of 10 incontinent			outcome.		
		ed for toileting on the			2. As stated in the 2567, the	:	
		as the potential to affect			facility had added staff and real duties in an effort to assist the s	-	
		s residing on the East			completing their tasks and was	wii iii	
	`	C, Resident #D, Resident			monitoring the effectiveness.		
		Resident #G, Resident			Additionally, the facility		
	#H, Resident #I a	and Resident #K)			redistributed nursing staff over		
					units to decrease the staff:reside ratio. Interview with staff indic		
	Findings include	:			the new pattern is working well		
		0/0/0044			allows them more time to spend		
	-	or on 8/3/2011 at 7 p.m.,			residents.		
		ses and two CNAs were			3. Nursing staff were inservi		
		ssigned to work on the			on the redistribution of staff and	1	
	East unit. The Ea	ast unit had a census of 33			encouraged to give		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155446	A. BUI	LDING	00	COMPLETED 08/05/2011
		155440	B. WIN			06/05/2011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	ITFR	1	'ILKIE DRIVE VAYNE, IN46804	
				<u> </u>	W/(TVL, IIV+000+	1 (7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	residents accordi	ng to the resident roster.			feedback/suggestions on recent	
	1. a. Resident ## 08/03/11 at 7:00 asleep. The resider from 7:00 P.M checked for incortoileting. At 10:1 #8 scheduled to wand there was onto on the East unit. worked alone untanother CNA can #I was on every to change. b. Resident #K wat 7:00 P.M., sear chair by the nurse was noted to be a out of her chair. and #12 pushed Fechanged her and From 7:27 - 11:00	4 P.M., Resident #K			feedback/suggestions on recent changes. DON/designee will monitor effectiveness 3x weekl through observations and interval Results of audits will be forwarded to QA&A for tracking and trending monthly times 3 months then quarterly thereafte	y view.
		room in her bed. She was				
		ncontinence. Resident				
	#K was on every	two hour check and				
	change.					
	10:00 P.M. indicates the been in bed in the	NA #5, on 08/03/11 at ated Resident #K had e afternoon and had been ntinence prior to getting				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155446		A. BUI	ILDING	NSTRUCTION 00	(X3) DATE COMP. 08/05/2	LETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A 5700 WI	DDRESS, CITY, STATE, ZIP CODE LKIE DRIVE /AYNE, IN46804	00/00/1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	her up for supper	r.					
	at 7:00 P.M., lyin remained in her besident #F. Into 08/03/11 at 7:00 #F had been in besident #D remains besident beside	was observed on 08/03/11 ted in her room in her e her bed. Her and oriented Resident #S, quently come out into the urse's station and request r roommate, Resident #D. aained in her wheelchair ntil 7:53 P.M. when she by four staff into her bed, and LPN's #10 and 12. ttocks was noted to be e had an open area on her cks, and she had been er bowels.					
	changed before supper. Resident hour check and continent of he supper. Resident #D was noted to free thallway to the number of the supper beside her bed up was transferred by CNA's #5 and 8, Resident #D's but bright red and shoright upper butto incontinent of her supper supp	the was gotten up for the #F was on every two change. was observed on 08/03/11 ted in her room in her ele her bed. Her and oriented Resident #S, quently come out into the arse's station and request roommate, Resident #D. tained in her wheelchair and 17:53 P.M. when she by four staff into her bed, and LPN's #10 and 12. ttocks was noted to be the had an open area on her cks, and she had been the bowels.					

000476

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU COMPLE		
ANDILAN	OF CORRECTION	155446	1	LDING	00	08/05/20	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF F	PROVIDER OR SUPPLIER				ILKIE DRIVE		
		TH AND REHABILITATION CEN	NTER	1	VAYNE, IN46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
IAG		to her bed the previous		IAG		+	DATE
		ambulance staff after					
		mitted from an acute care					
	"	lity. She indicated she					
		let and/or check the					
		7:53 P.M., when she was					
	_	ransferred to her bed					
		led assistance and was					
	unsure of the me	thod going to be utilized					
	to transfer Reside	ent #D. Resident #D was					
	on every two hou	ir check and change.					
		esident #D and her					
		ent #S, following the					
	· · · · · · · · · · · · · · · · · · ·	cated she had not been					
		had received a shower					
	around 10:30 A.N	М.					
	e. On 08/03/11 a	at 7:00 P.M., Resident					
	#H was observed	in her wheelchair beside					
	her bed. CNA #8	3 was noted to be in the					
	room changing th	ne bed linens. Resident					
	I	questing to go to bed.					
		e was hurting because she					
	had been sitting s	•					
	l '	7:35 P.M., Resident #H					
		ner bed. Resident #H					
	I -	two hour check and					
	change schedule.						
	Interview with C	NA #8 on 08/03/11 at					
		cated she had toileted					
	·	ore supper when she got					
		She indicated the					

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPLETED		
		155446	B. WIN			08/05/2011		
NAME OF F	AD OUTDED ON GUIDNI TED				ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER			5700 W	ILKIE DRIVE			
		TH AND REHABILITATION CEN	TER		VAYNE, IN46804			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETIO DATE)N	
IAG		LSC IDENTIFYING INFORMATION)	-	IAG	221 Telakery	DATE		
		been checked again for						
	incontinence unti	il she was placed in bed.						
	2 - 0 - 00/04/1	1 -4 0-20 A.M. D 1 4						
		1 at 9:20 A.M., Resident						
		be in the main lounge at a						
		service. Resident #I						
		main lounge until 11:21						
		Beautician, whose shop						
	,	cent to the main lounge,						
		dent was taken from the						
	_	ne dining room by						
	activity staff.							
	A	ΙΛ Ψζ						
	,	NA #6 was noted to assist						
		d. Interview with CNA						
		resident was a one person						
		was to be checked and						
	_	dicated she changed the						
		e put her to bed, but she						
	did not offer to to	oilet the resident.						
	1 0 00/04/15	40.20 A.M. D						
		at 9:20 A.M., Resident						
		seated in her reclining						
		ne nurse's station asleep.						
		ained in her reclining						
		A.M 10:55 A.M., when						
	=	CNA #3 to the assisted						
	dining room for l	unch.						
		NA #3 put resident #K to						
	bed and changed	her incontinence brief.						
		t 9:20 A.M., Resident						
	#G was observed	seated in her wheelchair						

000476

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155446	B. WIN			08/05/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	t .		5700 W	ILKIE DRIVE		
		TH AND REHABILITATION CEN	ΓER		VAYNE, IN46804		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)	+	TAG	BLI ICILIACI)		DATE
		nurse's station. The					
		d she needed help					
		afraid of people trying to					
	"get her." LPN #9 was alerted and						
		ked with Resident G.					
		nained in her wheelchair					
	across from the	nurse's station from 9:20 -					
	11:09 A.M. At 1	1:09 A.M., LPN #9					
	pushed Resident	#G to the assisted dining					
	room. She was i	not toileted or offered to					
	be changed prior	to going to the dining					
	room.						
	At 12:25 P.M01	n 08/04/11, Resident #G					
	1	in her wheelchair in the					
		ake, watching television.					
	1	PN #9 pushed Resident					
	1	n lounge to her room and					
	1	neelchair beside her bed.					
	At 2:00 P.M., Cl						
		lent #G to her bed and					
	1 -	dent. Resident #G's brief					
	1	rere scars from previous					
	_	he resident skin was not					
	1 -	#G was on an every two					
	hour check and o	change schedule.					
		at 9:20 A.M., Resident #F					
	1	ng in a reclining Broda					
	chair across fron	n the nurses station. She					
	remained in the	Broda chair asleep from					
	9:20 A.M 10:4	5 A.M. At 10:45 A.M.,					
	1	staff members were					
	observed to repo	sition and pull the					

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155446	A. BUI	LDING	00	08/05/2	
		100440	B. WIN			06/03/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	NTFR		/ILKIE DRIVE NAYNE, IN46804		
		TATEMENT OF DEFICIENCIES			I		(V5)
(X4) ID PREFIX		CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	resident up in the	Broda chair. At 11:04					
	A.M., CNA #3 pushed Resident #F to the assisted dining room. She was not						
	_	ntinence or toileted.					
	On 08/04/11 at 12:25 P.M., Resident #F						
	was observed stil	l in her Broda chair by					
	the nurse's station	n in the hallway. At 1:00					
	P.M., CNA's #3 a	and #6 transferred					
		her reclining chair to her					
	bed with a mechanical lift. The resident's brief was changed and the resident was						
	noted to have been incontinent of both her						
	bladder and bow	els.					
		at 9:20 A.M., Resident					
		be in his wheelchair in					
	_	at an activity. He					
		main lounge from 9:20 -					
		1:20 A.M., CNA #6 put					
	_	wheelchair pedals and					
	_	etly to the dining room. not toileted or checked					
	for incontinence.						
	101 incontinence.						
	On 08/04/11 from	n 12:25 P.M 12:40					
		E was noted to be					
	1 '	ily members. At 1:30					
	_	E was transferred by					
		From the wheelchair into					
		dent's brief was wet and					
	there was a slight						
		. In addition, there were					
		tion from the brief and					

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155446	B. WIN			08/05/2	011
NAME OF I	DOLUBER OF GURRI IER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	Į	
NAME OF I	PROVIDER OR SUPPLIER			5700 W	ILKIE DRIVE		
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	ITER	FORT V	WAYNE, IN46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENC!)		DATE
	l *	resident's buttocks and					
	1 ^ ^ ^	high. Resident #E was on					
	· ·	r check and change					
	schedule.						
	f. On 08/04/11 at 9:20 A.M., Resident #C						
	was observed sea	ated in a Broda reclining					
	chair in the hallw	yay near her room. She					
	was placed in the	e doorway of her room at					
	10:20 A.M. She	remained in her					
	wheelchair in the doorway to her room, until 10:55 A.M., when she was taken by						
		ed dining room. The					
		checked for incontinence					
		2:25 P.M., on 08/04/11,					
		observed back in her					
		e doorway to her room.					
		her Broda chair until					
		CNA's #3 and #6 placed					
		anged her brief. She was					
		dent #C was on an every					
		and change schedule.					
		S					
	g. On 08/04/11 a	at 10:00 A.M., Resident					
	#D was changed	and transferred to her					
	wheelchair by Cl	NA's #3 and #6. She					
	remained in her v	wheelchair in the hallway					
	by the telephone	until 11:12 A.M., when					
	she was taken to	the shower room by					
	CNA #13 and we	eighed in her wheelchair.					
	She was then pla	ced back by the					
	telephone and the	e nurse's station on the					
	East unit. At app	proximately 11:20 A.M.,					
	Resident #D was	pushed in her					

AND PLAN OF CORRECTION IDENTIFIC		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155446		LDING	NSTRUCTION 00	(X3) DATE : COMPL 08/05/2	ETED
	PROVIDER OR SUPPLIER	IL		5700 W	ADDRESS, CITY, STATE, ZIP CODE ILKIE DRIVE VAYNE, IN46804		
(X4) ID PREFIX	SUMMARY S	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
	for lunch. She w	PN #9 to the dining room was not toileted or entinence prior to being ng room.					
	was again in her station. At 1:12	2:25 P.M., Resident #D wheelchair by the nurse's P.M., LPN #9 pushed					
	hair. She was in out in the hallwa	k to her room to braid her nmediately placed back by by the nurse's station					
	after her hair was braided. She was not toileted. At 2:00 P.M., Resident #D remained in her wheelchair in the hallway						
	#D indicated her	nurse's station. Resident husband was picking her randson's birthday party [.					
	worked from 7/1	he staffing pattern as /2011 to 8/5/2011 Director of Nursing on					
	licensed nurses a	a.m., indicated two and two CNAs were ed to the East unit for day					
	and evening shif 33 residents. Ad	ts consistently to care for ditionally, one nurse and					
		signed for night shift 17 Two CNAs were assigned e other 19 days.					
	In an interview of LPN #4 indicate	on 8/3/2011 at 8:25 p.m. d two CNAs were not e to toilet those who					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155446		LDING	NSTRUCTION 00	(X3) DATE COMPI 08/05/2	LETED	
	PROVIDER OR SUPPLIER	IL : LTH AND REHABILITATION CEN	STREET A	DDRESS, CITY, STATE, ZIP CODE ILKIE DRIVE VAYNE, IN46804	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	needed it every t					
	CNA #5 indicate everyone toiletec sometimes could	on 8/3/2011 at 8:28 p.m., and it was very hard to get d before bed and they I not get finished with they did not have				
	CNA #6 indicate not enough staff CNA #6 addition administration has	on 8/4/2011 at 12:35 p.m., and sometimes there was to get everything done. In ally indicated and been made aware of so unwilling to change.				
	11:00 P.M., indi	ENA #11, on 08/03/11 at cated she was the only om 10:00 P.M 12:00 d shift.				
	08/04/11 at 1:00 not always enough change incontine on the day shift. licensed nurses the answering call lists ome care needs always enough the and/or incontine of the state	ghts and taking care of , but there still was not ime to get all the toileting nce checks completed.				
		NA #8, on 08/03/11 at attack she could not always				

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155446	B. WIN			08/05/2	011
			_		ADDRESS, CITY, STATE, ZIP CODE	·	
NAME OF E	PROVIDER OR SUPPLIER	•		5700 W	/ILKIE DRIVE		
	TON MANOR HEAL	TH AND REHABILITATION CEN	TER	FORT \	WAYNE, IN46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCT)		DATE
	-	eting and incontinence					
		the number of residents					
		who required mechanical					
	· ·	extra time. CNA's #8					
		they had 12 residents					
	1 *	nechanical lift and 2 more					
		ere being considered for a					
	mechanical lift tr	ansfer.					
	A form, presented by the DON on 08/04/11 at 10:00 A.M., indicated there						
	were 33 residents	s on the East unit, 26					
	required a 1 pers	on assist for toileting					
	needs, 1 person v	who required a two					
	person assist for	toileting needs, and 10					
	residents who red	quired a mechanical lift					
		16 resident who required					
	a 1 person assist	_					
	•						
	Observations of	care on 08/03/11 from					
	7:00 P.M 11:00	P.M., and on 08/04/11					
	from 9:20 A.M.	- 11:20 A.M. and 12:25					
	P.M 2:00 P.M.	, indicated the					
	mechanical lift tr	ransfer and incontinence					
	checks required a	a minimum of 10 minutes					
	of staff time and	required two staff					
		0 minutes times 10					
	_	esidents took 100 minutes					
	of staff time per	CNA. When repeated					
	_	nift, as indicated in each					
		an, an incontinence check					
		a mechanical lift would					
		tes of the total 420					
		per CNA for one shift,					
	minutes of staff	or Civilion one sinit,			l		

	OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE S COMPL	
AND TEAN	or conduction	155446		LDING		08/05/2	
		100110	B. WIN		DDRESS, CITY, STATE, ZIP CODE	00/00/2	
NAME OF I	PROVIDER OR SUPPLIER				ILKIE DRIVE		
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	ITER	1	VAYNE, IN46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		30 minutes for a staff					
		s, there would only be					
	1 **) minutes of CNA staff					
	_	utilize to toilet the other					
		required assistance to					
	· ·	ther 16 residents, assist					
	1	m during two meals on					
	I -	one meal on the evening					
		tra nourishment snacks,					
		rith transportation to and					
	from activities and meals, and provide						
	showers as scheduled.						
		vith the Director of					
	1	011 at 11:20 A.M., she					
		ility had been working on					
	1	ecognized it was hard for					
	_	their work completed. A					
	document was pr	ovided during the					
		ing a second CNA was					
		8 hours on the third shift					
		. The get up list had been					
	1 *	night and day shift the					
	second week of J	une, but the exact date					
	was not indicated	l, Shower redistribution					
	was implemented	d on July 25, 2011. The					
	shower redistribu	ition changed the times					
	of the showers to	before meals. The					
	facility was still i	monitoring this change to					
	evaluate its effec	tiveness. She indicated					
	staff could ask fo	or help if they were					
	unable to get their	ir assignments completed					
	and she felt the E	East Unit was adequately					
<u> </u>	staffed and was "	over budget."					
				•			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/30/2011 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPI	LETED	
		155446	1	LDING		08/05/2	2011	
		100110	B. WIN					
NAME OF F	PROVIDER OR SUPPLIEF	8		1	ADDRESS, CITY, STATE, ZIP CODE			
			5700 WILKIE DRIVE					
		LTH AND REHABILITATION CENT	ΓER	FORT \	NAYNE, IN46804			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	Refer to F282 re	lated to failure to follow						
	health care plans	related to toileting,						
	•	nagement and mechanical						
	lift transfers.	nagement and meenamear						
	iiit transiers.							
	Refer to F312 re	lated to failure to ensure						
		re residents were toileted						
	•							
	and/or, provided	timely incontinence care.						
	This Federal tag	relates to Complaint						
	IN00094006.	relates to Complaint						
	11100094000.							
	3.1-17(a)							
	2.1 17 (w)							

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Event ID:

7VIW11

Facility ID: 000476

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I		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
		155446	B. WIN			08/05/2	011
			D. WIIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L			ILKIE DRIVE		
COVING	TON MANOR HEAL	TH AND REHABILITATION CENT	ER		VAYNE, IN46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		ΓE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		ļ	TAG	DEFICIENCY)		DATE
F0441 SS=E	Infection Control F a safe, sanitary an and to help prever transmission of dis (a) Infection Contr The facility must e Program under wh (1) Investigates, co infections in the fa (2) Decides what p isolation, should b resident; and (3) Maintains a rec corrective actions (b) Preventing Spr (1) When the Infect determines that a prevent the spread must isolate the re (2) The facility must	establish an Infection Control nich it - ontrols, and prevents acility; procedures, such as e applied to an individual cord of incidents and related to infections. read of Infection ction Control Program resident needs isolation to d of infection, the facility					
		t contact with residents or contact will transmit the					
	hands after each o	st require staff to wash their direct resident contact for ng is indicated by accepted ice.					
	transport linens so infection.	andle, store, process and o as to prevent the spread of			P.44		
	interview, the factor of the f	ation, record review, and cility failed to ensure 3 of providing incontinence e facility policy regarding eaning technique. This	F0	441	F 441 1. Residents D, E, F, and H been reviewed and has not experienced any negative outco 2. The facility reviewed infecontrol logs with no trends note	me. ction	08/30/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY OO COMPLETED					
AND PLAN	OF CORRECTION		A. BUI	LDING	00		
		155446	B. WIN			08/05/2	011
NAME OF I	PROVIDER OR SUPPLIER	2		1	ADDRESS, CITY, STATE, ZIP CODE		
COVINC		TH AND DEHABILITATION CEN	ITED	1	ILKIE DRIVE		
		LTH AND REHABILITATION CEN	EK		VAYNE, IN46804		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION DATE
IAG	+			IAG	Central supply has increased the	3	DAIL
	affected 4 of 10 residents observed for incontinence care in a sample of 10.				number of times gloves are pass		
		*			weekly and placed a supply in a		
	(Residents D, E,	r, and H)			central location for staff use.		
	Eindings in sluds				3. Nursing staff will be inser		
	Findings include: 1. Resident #D was observed on 08/03/11				on proper glove usage and clear techniques for incontinent resid		
					Nursing staff has been inservice	ed on	
		eiving incontinence care.			where to find extra supplies of g	-	
		s noted to have on an			and how to obtain. SDC/design will monitor compliance throug		
	unfastened incontinence brief and had been incontinent of bowel when she was transferred from the wheelchair to her				random observations 2x weekly		
					4. Results of audits will be		
					forwarded to QA&A for tracking	-	
	bed. CNA #8 was noted to bring one				trending monthly times 3 month	ns	
		cloth and one wet			then quarterly thereafter.		
		ne dry towel to the					
		onning gloves, CNA #8					
		sh the resident's perineal					
		n sides of the soapy and					
	"	as she washed. LPN #12					
	then reentered th	e room and donned					
	gloves, utilized t	he soiled washcloths to					
	1	owel movement up and					
	_	nt's buttock area. The					
		ed to have an open					
		her upper right buttock.					
	<u> </u>	11 0					
	2. CNA's #3 and	d 6 were observed					
	transferring and	providing incontinence					
	care for Residen	t #F on 08/04/11 at 1:00					
	P.M. CNA #3 w	as noted to don gloves					
	and clean the res	ident's perineal area and					
	buttock area. Th	ne resident had been					
	incontinent of a	large amount of soft					
		then without removing					

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155446	A. BUI	LDING	00	COMPL 08/05/2	
		155440	B. WIN			00/03/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	ITER	1	VAYNE, IN46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	DATE
	his contaminated	gloves, adjusted the					
	resident's oxygen tubing and clipped the call light to the bed sheet before removing						
	his gloves.	_					
	3. CNA's #3 and 6 were observed						
	performing incor	ntinence care for Resident					
	#E on 08/04/11 a	t 1:30 P.M. CNA #6 was					
		e resident's perineal and					
		gloved hands. The					
	resident had been incontinent of urine and a small amount of bowel movement.						
	1	e resident, CNA #6 did					
	·	loves before pulling up					
	the blankets for F						
		ervation on 8/5/2011 at					
		#3 performed hand					
	''	red. CNA #3 then					
		#H's perineal area,					
	rinsed, and then of						
	** *	NA #3 then proceeded to					
		ef, reposition the resident					
		lankets without taking off					
	gloves or perforn	ning hand hygiene.					
	A assummant == =1: -	dated 2006 titled Davis and					
		dated 2006 titled Perineal					
		change gloves after					
	drying the resider						
	repositioning or o	covering the resident up.					
	In an interview o	n 8/3/2011 at 8 p.m.,					
		d gloves were allocated to					
		one person and the staff					
		ey to get into the area					
	ara not nave a ke	y to got into the area					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155446	ľ	MULTIPLE CO JILDING ING	00	COMP 08/05/2	LETED
	PROVIDER OR SUPPLIER	II : .TH AND REHABILITATION CEN	I	STREET A 5700 W	IDDRESS, CITY, STATE, ZIP COD ILKIE DRIVE VAYNE, IN46804	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	In an interview of CNA #2 indicate of gloves in the r was an issue. On 8/5/2011 at 1 observation of car glove availability but had plenty of	on 8/4/2011 at 9:30 A.M., d having adequate boxes from to care for residents 1:00 a.m., during fire, CNA #3 indicated was an issue at times, are gloves today. The relates to Complaint					